DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-01

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICAID AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 03-008B

2. STATE: OHIO

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
March 27, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR part 441 – Subpart C; 42 CFR Part 441 – Subpart D; 42 CFR part 447 – Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $(55,598,330)
b. FFY 2004 $ 8,576,750

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Pages ~~15~~20-22 of Attachment 4.19-A,
Rules ~~5101:3-2-09 and~~ 5101:3-2-10.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Pages ~~15~~20-22 of Attachment 4.19-A,
Rules ~~5101:3-2-09 and~~ 5101:3-2-10.

10. SUBJECT OF AMENDMENT:

Disproportionate share and indigent care adjustments for general hospitals and psychiatric hospitals.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X☐ OTHER, AS SPECIFIED: Governor has delegated review to ODJFS Director.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Thomas J. Hayes

13. TYPED NAME: Thomas J. Hayes

14. TITLE: Director

15. DATE SUBMITTED: May 12, 2003

16. RETURN TO:

Ohio Department of Job and Family Services
30 E. Broad Street, 27th Floor
Columbus, Ohio 43215

Attention: Becky Jackson
Bureau of Health Plan Policy

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MAY 28 2003

18. DATE APPROVED: OCT 21 2003

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: MAR 27 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Brian J. Smith

21. TYPED NAME: Charlene Brown

22. TITLE: Deputy Director, CMSO

23. REMARKS:

Disproportionate share and indigent care payment policies for psychiatric hospitals

This section applies to hospitals eligible to participate in Medicaid only for the provision of inpatient psychiatric services to eligible recipients and is applicable for the period ending September 30, 2003:

1. Age 65 and older; and
2. Under age 21, or if the recipient was receiving services immediately before he/she reached age 21, services are covered until the earlier of the date he/she no longer requires the services or the date he/she reaches age 22.

The payment policies described below are in accordance with rule 5101:3-2-10. Hospitals eligible to participate only for the provision of inpatient psychiatric services are limited, in accordance with rule 5101:3-2-01, to psychiatric hospitals, and certain alcohol and drug abuse rehabilitation hospitals, that are certified by Medicare for reimbursement of services and are licensed by the Ohio Department of Mental Health or operated under the state mental health authority.

A. Source data for calculations

The calculations described in determining disproportionate share psychiatric and certain alcohol and drug abuse rehabilitation hospitals (hospitals) and in making disproportionate share and indigent care payments will be based on financial data and patient care data for psychiatric inpatient services provided for the hospital fiscal year ending in state fiscal year **2002**.

B. Determination of disproportionate share hospitals

The department makes additional payments to hospitals that qualify for a disproportionate share adjustment. Hospitals that qualify are those that meet at least one of the criteria described under (1) and (2) below, and that also meet the criteria described under (3) below:

(1) The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in the state.

The Medicaid inpatient utilization rate is the ratio of the hospital's number of inpatient days attributable to patients who were eligible for medical assistance and who are age twenty-one and under or age sixty-five and older, divided by the hospitals total inpatient days.

(2) The hospital's low-income utilization rate is in excess of twenty-five percent.

The low-income utilization rate is the sum of:

(a) The sum of total Medicaid revenues for inpatient services and cash subsidies for inpatient services received directly from state and local governments, divided by the sum of total facility inpatient revenues and cash subsidies for
patient services received directly from state and local governments, plus

(b) Total charges for inpatient services for charity care (less cash subsidies above, and not including contractual allowances and discounts other than for indigent patients ineligible for Medicaid) divided by the total charges for inpatient services.

(3) A Medicaid inpatient utilization rate greater than or equal to one percent.

C. Determination of hospital disproportionate share groups for payment distribution

Hospitals determined to be disproportionate share as described above will be classified into one of four tiers for payment distribution based on the data described in paragraph a above. The tiers are described below:

(1) Tier one includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate grater than 25% but less than 40%, or hospitals with a low-income utilization rate less than or equal to 25% that are deemed a disproportionate share hospital based on a Medicaid inpatient utilization rate that is one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in the state.

(2) Tier two includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 40% but less than 50%.

(3) Tier three includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 50% but less than 60%.

(4) Tier four includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 60% .

D. Distribution of funds within each hospital tier

The funds available in a tier are distributed among hospitals in that tier according to the payment formulas described below. Hospitals will be distributed a payment amount based on the lesser of their uncompensated care costs or their disproportionate share payment. Uncompensated care costs are defined as total inpatient allowable costs less insurance revenues, self-pay revenues, total Medicaid revenues and uncompensated care costs rendered to patients with insurance for the service provided. Each hospital's disproportionate share payment is calculated on a tier-specific basis as follows:

$$\frac{\text{Hospital specific uncompensated care Costs}}{\text{sum of uncompensated care costs for all hospitals in the tier}} \times \text{Disproportionate share funds available for distribution in the tier}$$

(1) Funds available for distribution by tier.

(a) Tier 1. A maximum of 5% of the disproportionate share funds will be distributed to the hospitals in tier one.

If no hospitals fall into tier one, or all funds are not distributed, then undistributed funds from tier one will be added to the funds available for distribution in tier four.

(b) Tier 2. A maximum of 25% of the disproportionate share funds will be distributed to hospitals in tier two.

If no hospitals fall into tier two, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four.

(c) Tier 3. A maximum of 45% of the disproportionate share funds will be distributed to hospitals in tier three.

If no hospitals fall into tier three, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four.

(d) Tier 4. A minimum of 40% of the disproportionate share funds will be distributed to hospitals in tier four.

(2) Payment distribution

Each hospital will be distributed a payment amount based on the lesser of their:

(a) Uncompensated care costs; or

(b) Disproportionate share payment amount

E. Disproportionate share funds

The maximum amount of disproportionate share funds available for distribution to psychiatric hospitals will be determined by subtracting the funds distributed in accordance with rule 5101:3-2-09 of the administrative code from the state's disproportionate share limit as described in subparagraph (f) of section 1923 of the Social Security Act, 49 Stat. 620 (1935), 42 USC 1396-r-4 (f), as amended.

*** DRAFT - NOT YET FILED ***

5101:3-2-10 **Payment policies for disproportionate share and indigent care adjustments for psychiatric hospitals.**

This rule is applicable for the program year that ends in calendar year ~~2002~~2003, for all medicaid-participating psychiatric hospitals as described in paragraphs (B), (C) and (D) of rule 5101:3-2-01 of the Administrative Code.

(A) Definitions.

(1) "Inpatient days" means for each psychiatric hospital the number of inpatient hospital days as reported in JFS 02930, schedule C, column 4 plus the number of inpatient hospital days that would have been covered by medicaid if medicaid coverage were available to the population served age twenty-two to sixty-four as reported on JFS 02930, schedule F, column 6, line 24.

(2) "Insurance revenues" are reported on JFS 0290, schedule F, column 1, line 24 and mean for each psychiatric hospital the revenues received in the same twelve months of the hospital's cost-reporting period for inpatient services provided to, billed to, and received from all sources other than medicaid or self-pay revenues as described in paragraph (A)(4) of this rule.

(3) "Medicaid inpatient utilization rate" means for each psychiatric hospital the ratio of the hospital's number of inpatient days attributable to patients who were eligible for medical assistance as described in paragraph (A)(6) of this rule divided by the hospital's total inpatient days as described in paragraph (A)(1) of this rule.

(4) "Self-pay revenues" means for each psychiatric hospital the revenues received in the same twelve months of the hospital's cost-reporting period for inpatient services provided to, billed to, and received from either the person that received inpatient services or the family of the person that received inpatient services as reported on JFS 02930, schedule F, column 2, line 24.

(5) "Total inpatient allowable costs" for each psychiatric hospital means the sum of the general service and capital related costs for inpatient hospital services reported in JFS 02930 schedule B, column 7.

(6) "Total medicaid days" for each psychiatric hospital means the amount on JFS 02930, schedule C, column 6, line 35 plus the number of days that would have been covered by medicaid if medicaid coverage were available to the population served age twenty-two to sixty-four as reported on JFS 02930,

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schedule F, column 6, line 24.

(7) "Total medicaid revenues" for each psychiatric hospital means the sum of the amounts reported on JFS 02930, schedule H, section I, column 1, line 8.

(8) "Uncompensated care costs" means for each psychiatric hospital the total inpatient allowable costs as described in paragraph (A)(5) of this rule less total facility revenue as described in paragraph (A)(12) of this rule less the uncompensated care costs rendered to patients with insurance for the services provided as described in paragraph (A)(9) of this rule.

(9) "Uncompensated care costs rendered to patients with insurance" means the costs for an individual that has insurance coverage for the service provided, but the full cost of the service was not reimbursed because of per diem caps or coverage limitations as reported on JFS 02930, schedule F, column 5, line 24.

(10) "Charges for charity care" means for each psychiatric hospital the total charges for inpatient services provided to indigent patients as reported on JFS 02930, schedule F, column 3, line 24. It includes charges for services provided to individuals who do not possess health insurance for the service provided. However, charity care does not include bad debts, contractual allowances or uncompensated care costs rendered to patients with insurance as described in paragraph (A)(9) of this rule.

(11) "Total charges for inpatient services" means for each psychiatric hospital the amount reported for inpatient hospital services in JFS 02930, schedule B, column 6.

(12) "Total facility inpatient revenues" means for each psychiatric hospital the sum of the hospital's insurance revenues as described in paragraph (A)(2) of this rule, self-pay revenues as described in paragraph (A)(4) of this rule, and total medicaid revenues as described in paragraph (A)(7) of this rule.

(13) "Cash subsidies for inpatient services received directly from state and local governments" means for each psychiatric hospital the amount of cash subsidies each psychiatric hospital has received from state and local governments as reported on JFS 02930, schedule F, column 4, line 24 and as reported by each hospital in accordance with paragraph (C) of this rule.

(B) Applicability.

The requirements of this rule are limited pursuant to section 1923 of the Social Security Act, 42 USC 1396r-4.

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(C) Source data for calculations.

The calculations described in paragraphs (D), (E), and (F) of this rule for disproportionate share payments for program year ~~2002~~2003, will be based on financial data and patient care data for psychiatric inpatient services provided for the fiscal year ending in state fiscal year ~~2001~~2002 and as reported by each hospital through a survey instrument as required by the department.

(D) Determination of disproportionate share qualifications for psychiatric hospitals.

Psychiatric hospitals will be determined to be disproportionate share if based on data described in paragraph (C) of this rule they meet either qualification described in paragraph (D)(1) or (D)(2) of this rule and meet the qualification in paragraph (D)(3) of this rule.

(1) The hospital's medicaid inpatient utilization rate, as described in paragraph (A)(3) of this rule, is at least one standard deviation above the mean medicaid inpatient utilization rate for all hospitals receiving medicaid payments in the state; or

(2) A low-income utilization rate in excess of twenty-five per cent, where the low-income utilization rate, the fraction expressed as a percentage, is the sum of:

(a) The sum of total medicaid revenues as described in paragraph (A)(7) of this rule, for inpatient services and cash subsidies for inpatient services received directly from state and local governments as described in paragraph (A)(13) of this rule, divided by the sum of total facility inpatient revenues as described in paragraph (A)(12) of this rule, and cash subsidies for inpatient services received directly from state and local governments as described in paragraph (A)(13) of this rule, plus

(b) Total charges for inpatient services for charity care as described in paragraph (A)(10) of this rule (less cash subsidies above, and not including contractual allowances and discounts other than for indigent patients ineligible for medicaid) divided by the total charges for inpatient services, as described in paragraph (A)(11) of this rule.

(3) A medicaid inpatient utilization rate as described in paragraph (A)(3) of this rule greater than or equal to one per cent.

(E) Determination of hospital disproportionate share groupings for payment distribution.

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Hospitals determined to be disproportionate share as described in paragraph (D) of this rule will be classified into one of four tiers based on data described in paragraph (C) of this rule. The groupings for payment distribution are described in paragraphs (E)(1) to (E)(4) of this rule.

(1) Tier one includes hospitals that meet the criteria in either paragraph (E)(1)(a) or (E)(1)(b) of this rule.

(a) Hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate as described in paragraph (D)(2) of this rule greater than twenty-five per cent but less than forty per cent .

(b) Hospitals with a low-income utilization rate as described in paragraph (D)(2) of this rule less than or equal to twenty-five per cent that are deemed a disproportionate share hospital based on a medicaid inpatient utilization rate as described in paragraph (D)(1) of this rule.

(2) Tier two includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate as described in paragraph (D)(2) of this rule greater than or equal to forty per cent but less than fifty per cent.

(3) Tier three includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate as described in paragraph (D)(2) of this rule greater than or equal to fifty per cent but less than sixty per cent.

(4) Tier four includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate as described in paragraph (D)(2) of this rule greater than or equal to sixty per cent.

(F) Distribution of funds within each hospital tier.

The funds available to each psychiatric hospital tier as described in paragraph (E) of this rule are distributed among the hospitals in each tier based on data described in paragraph (C) of this rule and according to the payment formulas described in paragraphs (F)(1) to (F)(4) of this rule.

(1) A maximum of five per cent of the disproportionate share funds available to psychiatric hospitals as described in paragraph (H) of this rule will be distributed to the hospitals in tier one as described in paragraph (E)(1) of this rule according to the process described in paragraphs (F)(1)(a) to (F)(1)(f) of this rule.

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(a) For each hospital in tier one, calculate the uncompensated care costs as described in paragraph (A)(8) of this rule.

(b) For all hospitals in tier one, sum all hospitals uncompensated care costs as described in paragraph (A)(8) of this rule.

(c) For each hospital in tier one, calculate the ratio of the amount described in paragraph (F)(1)(a) of this rule to the amount described in paragraph (F)(1)(b) of this rule.

(d) Multiply the ratio for each hospital calculated in paragraph (F)(1)(c) of this rule in tier one by the amount in paragraph (F)(1) of this rule to determine each hospital's disproportionate share payment amount.

(e) Each hospital will be distributed a payment amount based on the lesser of:

(i) Uncompensated care costs as determined in paragraph (A)(8) of this rule; or

(ii) The hospital's payment as determined in paragraph (F)(1)(d) of this rule.

(f) If no hospitals fall into tier one, or all funds are not distributed, then undistributed funds from tier one will be added to the funds available for distribution in tier four and be distributed in accordance with the process described in paragraphs (F)(4)(a) to (F)(4)(e) of this rule.

(2) A maximum of twenty-five per cent of the disproportionate share funds available to psychiatric hospitals as described in paragraph (H) of this rule will be distributed to the hospitals in tier two as described in paragraph (E)(2) of this rule according to the process described in paragraphs (F)(2)(a) to (F)(2)(f) of this rule.

(a) For each hospital in tier two, calculate the uncompensated care costs as described in paragraph (A)(8) of this rule.

(b) For all hospitals in tier two, sum all hospitals uncompensated care costs as described in paragraph (A)(8) of this rule.

(c) For each hospital in tier two, calculate the ratio of the amount described in

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paragraph (F)(2)(a) of this rule to the amount described in paragraph (F)(2)(b) of this rule.

(d) Multiply the ratio for each hospital calculated in paragraph (F)(2)(c) of this rule in tier two by the amount in paragraph (F)(2) of this rule to determine each hospital's disproportionate share payment amount.

(e) Each hospital will be distributed a payment amount based on the lesser of:

(i) Uncompensated care costs as determined in paragraph (A)(8) of this rule; or

(ii) The hospital's payment as determined in paragraph (F)(2)(d) of this rule.

(f) If no hospitals fall into tier two, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four and be distributed in accordance with the process described in paragraphs (F)(4)(a) to (F)(4)(e) of this rule.

(3) A maximum of forty-five per cent of the disproportionate share funds available to psychiatric hospitals as described in paragraph (H) of this rule will be distributed to the hospitals in tier three as described in paragraph (E)(3) of this rule according to the process described in paragraphs (F)(3)(a) to (F)(3)(f) of this rule.

(a) For each hospital in tier three, calculate the uncompensated care costs as described in paragraph (A)(8) of this rule.

(b) For all hospitals in tier three, sum all hospitals uncompensated care costs as described in paragraph (A)(8) of this rule.

(c) For each hospital in tier three, calculate the ratio of the amount described in paragraph (F)(3)(a) of this rule to the amount described in paragraph (F)(3)(b) of this rule.

(d) Multiply the ratio for each hospital calculated in paragraph (F)(3)(c) of this rule in tier three by the amount in paragraph (F)(3) of this rule to determine each hospital's disproportionate share payment amount.

(e) Each hospital will be distributed a payment amount based on the lesser of:

(i) Uncompensated care costs as determined in paragraph (A)(8) of this rule; or

(ii) The hospital's payment as determined in paragraph (F)(3)(d) of this rule.

(f) If no hospitals fall into tier three, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four and be distributed in accordance with the process described in paragraphs (F)(4)(a) to (F)(4)(e) of this rule.

(4) A minimum of forty per cent of the disproportionate share funds available to psychiatric hospitals as described in paragraph (H) of this rule will be distributed to the hospitals in tier four as described in paragraph (E)(4) of this rule according to the process described in paragraphs (F)(4)(a) to (F)(4)(e) of this rule.

(a) For each hospital in tier four, calculate the uncompensated care costs as described in paragraph (A)(8) of this rule.

(b) For all hospitals in tier four, sum all hospitals uncompensated care costs as described in paragraph (A)(8) of this rule.

(c) For each hospital in tier four, calculate the ratio of the amount described in paragraph (F)(4)(a) of this rule to the amount described in paragraph (F)(4)(b) of this rule.

(d) Multiply the ratio for each hospital calculated in paragraph (F)(4)(c) of this rule in tier four by the amount in paragraph (F)(4) of this rule to determine each hospital's disproportionate share payment amount.

(e) Each hospital will be distributed a payment amount based on the lesser of:

(i) Uncompensated care costs as determined in paragraph (A)(8) of this rule; or

(ii) The hospital's payment as determined in paragraph (F)(4)(d) of this rule.

(G) Payments.

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The department shall make payment in accordance with paragraphs (E) and (F) of this rule, for hospitals that are eligible to participate in Title XIX only for the provision of inpatient psychiatric services as described in rule 5101:3-2-01 of the Administrative Code that meet the criteria described in paragraph (D) of this rule.

(H) Disproportionate share funds.

The maximum amount of disproportionate share funds available for distribution to psychiatric hospitals will be determined by subtracting the funds distributed in accordance with rule 5101:3-2-09 of the Administrative Code from the state's disproportionate share limit as described in subparagraphs (f) and (h) of section 1923 of the Social Security Act, 42 USC 1396-r-4 (f)~~, as amended~~.

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Effective:

R.C. 119.032 review dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5111.02, 5112.03
Rule Amplifies:	5111.01, 5111.02, 5112.01 to 5112.21
Prior Effective Dates:	6/1/96 (Emer.), 8/12/95, 9/25/96 (Emer.), 12/5/96, 12/6/97, 9/10/98, 9/26/99, 9/28/00, 9/27/01, 7/22/02

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